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Credentialing Policy & Procedure Manual

I. PURPOSE:

The purpose of this manual is to define the Credentialing Program that the Medical Staff utilizes to verify the professional qualifications of all network providers, as well as providers making application for membership and/or privileges at Children's Hospital & Medical Center. The Credentialing Program's objective is to accomplish the Medical Staff and Managed Care credentialing functions outlined in this document, the scope of which is determined by a provider's qualifications and defined in Section IV of this document.

II. DEFINITIONS:

For purposes of this Medical Staff Document, the term "appropriate hospital representative" or "Medical Staff representative" includes the Board of Directors, President and Chief Executive Officer or designee, Medical Staff Officers, Medical Staff Services personnel and committees which have responsibility for collecting or evaluating the applicant's credentials or acting on the application.

The **Credentials Committee** is a peer-review body with members from the range of providers participating in the organization's network. At minimum, one member of the Credentials Committee will be a participating provider who is a practitioner with no other role in network management activities. The Credentials Committee will be chaired by a physician who is a Senior member of the Clinical Staff and is responsible for the oversight of the clinical aspects of the Credentialing Program. The Credentials Committee will meet monthly to fulfill its responsibilities which include:

- Review and discussion of whether providers are meeting reasonable standards of care. This will include review of FPPE and OPPE reports, as well as clinical peer input from providers of the same or similar specialties.
- Maintain minutes from all monthly meetings, including documentation of all actions taken.

- Provide guidance to credentialing staff on the overall direction of the Credentialing Program.
- Evaluate and reports to the appropriate hospital representative or Medical Staff representative on the effectiveness of the credentialing program
- Review and approve credentialing policies & procedures, including an annual review of this Credentialing Policies & Procedures manual and the Credentialing Program.

III. QUALIFICATIONS:

1. All licensed independent practitioners (LIPs) are required to be credentialed.
2. Appointment to the Medical Staff of Children's Hospital & Medical Center is a privilege that shall be extended only to competent professionals who continuously meet the qualifications, standards and requirements set forth in the Medical Staff Documents.
3. Only physicians with Doctor of Medicine, or equivalent, Doctor of Osteopathy, Doctor of Dental Surgery, and/or Doctor of Dental Medicine degrees holding a license to practice in the State of Nebraska or Iowa (dictated by practice location) shall be qualified for appointment to the Medical Staff. No application for appointment to the Medical Staff should be provided to any other type of provider.
4. Other providers, as defined in the *APP Manual*, will be permitted to apply for a job specific Scope of Service/Privileges as members of the Advanced Practice Staff as outlined in the *APP Manual*.
5. Allied Health Professionals, inclusive of but not limited to, Audiologists, Speech Language Pathologists, Lactation Consultants, Registered Dietitians, Licensed Medical Nutrition Therapists, Certified Diabetes Educators, Physical Therapists, and Occupational Therapists, may be credentialed as billing providers; but will not be granted privileges. These files will be designated as **Managed Care Credentialing Review Only and** will not require review and approval by the Medical Executive Committee and Board of Directors.
6. Providers who are employed by, and working in Children's Physician's clinics **only**, are not required to be privileged through the Medical Staff Office or apply for membership on the Medical Staff. These providers may choose to do so if they meet the qualifications outlined above. All physicians, APPs, and Allied Health Professionals employed by, and working in Children's Physician's clinics will be credentialed as billing providers. These files may be designated as **Managed Care Credentialing Review Only and** will not require review and approval by the Medical Executive Committee and Board of Directors.

IV. APPLICATION FOR INITIAL APPOINTMENT:

A. Upon receipt of a request for an application, Medical Staff Services will provide the potential applicant with the Application Form (application). The potential applicant must meet the following basic qualifications:

    1. Current valid license to practice unrestricted in the State of Nebraska, or Iowa (dictated by practice location.
    2. Current coverage of professional/malpractice liability insurance in the amount specified in the Medical Staff Bylaws.
    3. For Doctors of Osteopathy or Medicine only: Documentation of successful

completion of a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) for applicants applying after July 1, 1992. In lieu of ACGME/AOA residency, an Applicant for initial appointment or reappointment may provide alternative proof of competency, training and education. The Applicant shall bear the responsibility of showing that such alternative proof is comparable to ACGME residency programs and must provide such evidence at the time of the initial application or reappointment.

4. Current registration with the Drug Enforcement Administration (DEA), if applicable (Pathologists and CRNAs are exempt from this requirement. Other provider types may be granted privileges and/or appointment to the Medical Staff without a current DEA if their prescribing practice does not require one, or if they have an alternate prescriber arrangement on file with the Medical Staff Office).
5. Documentation of current legal authorization to work in the United States as issued by a government office assigned to do so, if applicable.

B. Each application for credentialing, clinical privileges and/or appointment to the Medical Staff shall be in writing, submitted on the Application form and signed and dated by the applicant. Applications must be signed and dated no more than 180 days prior to review by the Credentials Committee or Quality and Patient Safety Committee (QPSC) of the Board of Directors (whichever is serving as the final approving body). Occasionally, Medical Staff Services will utilize an external Credentials Verification Organization (CVO) to complete the primary source verification process. In these instances, Medical Staff Services will advise the applicant of this, as well as obtain prior approval from all delegated health plan entities

C. The application package shall include the following:
    1. **Application:** A completed Application form with required copies of documents (as outlined on the application form)
    2. **Application fee:** As specified in the application packet.
    3. **Acknowledgment and Agreement:** A statement that the applicant has received and read the Children's Hospital & Medical Center Medical Staff Documents and that the applicant agrees to be bound by the terms there of if the applicant is granted membership and/or clinical privileges; and to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or clinical privileges are granted; as well as an explanation of how the appointment process is structured (Not required for Managed Care Credentialing Review only files).
    4. **Qualifications:** Detailed information concerning the applicants qualifications, including information in satisfaction of the basic qualifications outlined in the Medical Staff Bylaws, and of any additional qualifications specified in the Medical Staff Documents for the particular staff category to which the applicant requests appointment.
    5. **Privilege Delineation Form (if applicable):** A completed privilege request form for which the applicant wishes to be considered. Additional supporting documentation of education, training and experience may be required by the Department Chair and/or Credentials Committee for special procedures or to determine competency.

6. **References:** The names and addresses of three providers, at least one of which is of the same professional discipline, who have firsthand knowledge of the applicant's professional performance in the past two years. Physician references will be queried in the National Provider Identifier (NPI) database to verify the provider listed is a practicing physician (Not required for Managed Care Credentialing Review only files).
7. **Professional Sanctions:** Information on previously successful or currently pending challenges or voluntary and involuntary relinquishments to any license or registration; information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily limited, relinquished, revoked, suspended, reduced, terminated or not renewed at another hospital or health care entity; as to whether any of the following have ever been voluntarily or involuntarily suspended, revoked, relinquished or denied. Sanctions, restrictions, or involuntary relinquishments of any of the below will result in the application receiving a Category II designation as defined in Section V.C. of this Credentialing Policies and Procedures Manual.
    a. Membership/fellowship in local, state, or national professional organizations.
    b. Specialty Board Certification.
    c. License to practice any profession in any jurisdiction.
    d. Drug Enforcement Administration (DEA) registration or State Controlled Substance Registration.
    e. Involvement or settlements in any professional liability action and final judgments or are pending.
    f. Any record of conviction of Medicare, Medicaid or insurance fraud and abuse, payment of civil money penalties for same or exclusion from such programs. Any record of any felony, misdemeanor related to professional practice, other health care related matters, third party reimbursement, violence, or controlled substance violations. If any such actions were ever taken or are pending, the particulars thereof shall be included.
8. **Professional Liability Insurance:** Proof that the applicant carries at least the minimum amount of professional liability insurance coverage as required in the Medical Staff Bylaws and any information on any past or current professional liability action including consent to the release of information by the applicant's present and past malpractice insurance carriers and/or legal counsel. Each applicant shall maintain in force professional liability insurance in an amount of not less than $500,000.00 per occurrence and $1,000,000.00 aggregate, or whatever limits are applicable as required by state law, and umbrella coverage extending such professional liability coverage to an aggregate of $3,000,000 (or as required by state law) through private insurance coverage or through a combination of insurance and qualification under and participation in the Nebraska Medical Liability Act, R.R.S. §44-2801, et seq.
9. **Notification of Release and Immunity Provisions:** Statement notifying the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of the Children's Hospital & Medical Center Consent and Release form

and the General Provisions outlined in the Medical Staff Bylaws.

10. **Administrative Remedies:** A statement whereby the applicant agrees that when an adverse ruling is made with respect to staff membership, status and/or clinical privileges, the applicant will exhaust the administrative remedies afforded by the Medical Staff Documents before resorting to formal legal action. (Not required for Managed Care Credentialing Review only files).
11. **Evidence of physical ability to perform the requested privileges,** if applicable
12. Documentation of successful completion of the **restraint education test** for those applicable providers with privileges.
13. **Any other items** as may be determined by the Medical Executive Committee

D. **Effect of Application:** By applying for appointment to the Medical Staff, the applicant:

1. Signifies his/her willingness to appear for interviews regarding his/her application if necessary.
2. Authorizes appropriate representatives of the Medical Staff to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications.
3. Consents to the inspection by appropriate representatives of the Medical Staff of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the clinical privileges he/she request as well as of his/her professional ethical qualifications for staff membership.
4. Releases from absolute liability all appropriate representatives of the Medical Staff for their acts performed without malice in connection with evaluating the applicant and his/her credentials.
5. Releases from all absolute liabilities all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.
6. Authorizes and consents to appropriate hospital representatives providing other hospital, medical associations, and licensing boards, and other organizations required by law with any information relevant to such matters which the hospital may have concerning him/her and releases hospital representatives from liability for so doing provided that such furnishing of information is done without malice.
7. Completes the Confidential Health Status Questionnaire and provides any information on current physical, mental health, and substance abuse status as requested by the Medical Executive Committee.

V. PROCESSING THE APPLICATION

A. **Applicant's Burden**

1. The applicant shall have the burden of producing adequate and current information for a proper evaluation of experience, background, training, and demonstrated ability.

Upon request of the Medical Executive Committee, or of the Board, a physical and mental health status statement and resolution of any doubts about the applicant's ability to meet these or any other basic qualifications specified in Article 3 (physicians), or Article 5 (APPs), of the Medical Staff Bylaws shall be provided. Any misstatement or omission from the application may be cause for rejection of the application and the applicant will not be entitled to any procedural rights as outlined in the Medical Staff Bylaws. The applicant attests to the accuracy of the application and agrees that any substantive omission or misrepresentation in the Medical Executive Committee or Board's opinion may be grounds for termination of the application process without access to a fair hearing or review.

2. An application shall be deemed incomplete if any required items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. Anytime in the credentialing process when it becomes apparent that an applicant does not meet all of the eligibility criteria for membership or privileges, the application process shall be terminated, no further action taken, and the applicant shall not be entitled to a fair hearing.
3. The applicant shall have the right to be informed of the status of their application, upon request. The status update will include notification of any missing documentation from the provider, as well as any outstanding items that need to be verified through the primary source. This request may be made verbally, or in writing, to Medical Staff Services.

B. **Verification of Information**

1. Upon receipt of a completed Application form, Medical Staff Services (MSS) will verify the contents and determine if the basic requirements specified in the Medical Staff Bylaws are met (where applicable). If there are questions regarding the acceptance of the application, the application will be forwarded to the President of the Medical Staff, or designee, for review and acceptance. Once accepted, the MSS will begin the primary source credentials verification to include:
    a. Verification of current and valid professional licensure in all states where the provider will be practicing.
    b. Verification of valid Drug Enforcement Agency (DEA), Controlled Dangerous Substance (CDS), or Controlled Substances Act (CSA) certificate, if applicable.
    c. Verification of all higher education and training, beginning with medical or professional school, or the ECFMG if applicable.
    d. Verification of board certification or board eligibility, if applicable.
    e. Verification of the most recent ten years of work history as a health professional, timeline of such to be provided through the provider's application and/or CV. If the provider has fewer than ten years of work history, the time frame starts at the initial professional licensure date. Any gaps in work history that exceed thirty (30) days will require a written explanation from the provider.
    f. Verification of the most recent ten years of health care affiliations to

include verification of Medical Staff membership status and hospital and/or ambulatory privileges, if applicable.

g. Verification of the past five years of malpractice insurance to include primary source verification of claims history from the malpractice carrier. The five-year period may include residency or fellowship years. If the provider does not have five years of malpractice insurance coverage, the time frame starts at the initial professional licensure date.

h. Verification of peer recommendations, including at least one from a provider in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and will include written information regarding the medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism (Not required for Managed Care Credentialing Review only files).

i. Verification of past or current sanctions; information to be included in the background check screening, and may be obtained from other sources such as the Federation of State Medical Boards (FSMB), National Practitioner Data Bank, American Medical Association (AMA), Office of Inspector General (OIG), System for Award Management (SAM), and the applicable State Medicaid exclusion lists.

j. Verification that the provider is enrolled and has an active Medicaid identification number. This includes verification that the provider is enrolled with the State of Nebraska and/or Iowa as an approved service provider for the Division of Medicaid and Long-Term Care (MLTC).

k. Results of the criminal background check evaluated and found to be satisfactory. The criminal background check will include a Fraud and Control Information System (FACIS) Level 3 screening. If convicted of a felony related to misuse of controlled substances, illegal drugs, fraud or abuse, violence or any act that would reflect adversely on the reputation of the health care organization and/or the confidence of the community, the provider shall automatically and voluntarily relinquish membership and privileges without right to a fair hearing or review.

l. Results of the **National Practitioner Data Bank** evaluated and found to be satisfactory.

2. In the event the requirements are not met, the potential applicant will be notified of the ineligibility to apply and will be given an opportunity for an informal discussion with the President of the Medical Staff, or designee. The potential applicant will not be entitled to any procedural rights as outlined in Article 8 and 9 of the Medical Staff Bylaws because of ineligibility to apply.

3. All documents which are verified through the primary source, see Addendum A, will be reviewed for completeness and accuracy by MSS. The credentialing specialist will sign (or initial) and date stamp all verifications obtained through the primary source. Documents which were provided by the applicant will also be date stamped as they are received. A checklist will be used to ensure that all required documents and

verifications have been obtained. All documents will become part of the provider's permanent credentialing file.

4. If information obtained from the primary source varies substantially from the information given by the provider to the organization, the provider will be contacted and notified of the discrepancy. The provider has the right to correct the erroneous information and will be required to submit a statement in writing to Medical Staff Services explaining the reason for the discrepancy. This information must be obtained within the processing time frame outlined in Section V.N of this Credentialing Policies and Procedures Manual or the file will be considered incomplete and the application process terminated. Every reasonable attempt will be made by the credentialing specialist to verify the provider's explanation with the primary source. If a substantial discrepancy still exists, the provider's file will be processed as a Cat II as defined in Section V.C of this Credentialing Policies and Procedures Manual.
5. If any documents in the provider's credentialing file are modified after they are received, either by the applicant, or through re-verification of the primary source; the reason for the modification will be documented by the credentialing specialist in the provider's credentialing file. The new or revised document will be signed, and date stamped by the individual performing the verification and included in the provider's credentialing file, along with the original document.
6. The MSS department will review all information in the credentialing file for completeness and accuracy. Staff will not modify any document without the written or documented verbal consent of the applicant or primary source. This documentation will be signed, and date stamped and included in the provider's credentialing file. Modification of a document may be appropriate in such circumstances where an affiliation date was entered incorrectly, or the wrong privileges were requested. Modifications should be indicated by a single line striking through the incorrect information, with the adjustor's initials and date next to the strike through. Other potential appropriate circumstances for documentation modification may be approved by the Manger or Director of Medical Staff Services, on a case-by-case basis, and documentation of such will be included in the provider's credentialing file. Staff members who are authorized to access, modify, and delete information that meet the above criteria include Sr. Credentialing Specialist, Credentialing Specialist, and Director, Medical Staff Services.
7. Deletion of information or permanent removal of documents from the provider's credentialing file is only appropriate if the information was entered or verified in error. All modifications to the application or verification documents should be handled in the manner outlined in Section V.B.5 of this Credentialing Policies and Procedures Manual.
8. When the collection of reference information and primary source verifications, which will include but not be limited to, licensure, query of NPDB, background check, relevant education and training and peer or faculty recommendations is accomplished, the MSS shall transmit the application and all supporting materials to the appropriate Department Chair and the Chair of the Credentials Committee for review. Action on an individual's application for appointment or initial clinical

privileges is withheld until the information is available and verified. If adequate information is not made available by the applicant, processing and/or approval of the application will cease.

C. **Determination of Category I or Category II File**
When all information is complete, the Credentialing Specialist shall review the application and make a preliminary determination of which category the application meets based on the criteria outlined below. Category I files may be granted temporary privileges as defined in Section 7.2-4 of the Medical Staff Bylaws. Category I files may also be presented to the Medical Executive Committee and the Board of Directors as consent agenda items, after review and approval by the Department Chair and Credentials Committee. Category II files are typically not eligible for temporary privileges but may be permitted and evaluated on a case-by-case basis, and only after review and approval by the Department Chair and Credentials Committee. Cat II files are not eligible for placement as a consent agenda item.

1. **Category I Application**
    a. All requested information has been returned promptly.
    b. There are no negative or questionable recommendations.
    c. There are no discrepancies in information received from the applicant or references.
    d. There have been no disciplinary actions or legal sanctions.
    e. There have been no malpractice claims/settlements/judgments.
    f. The applicant has an unremarkable medical staff/employment history.
    g. The applicant has submitted a request for clinical privileges based on experience, training, demonstrated competence consistent with his or her specialty, and is in compliance with applicable criteria.
    h. The applicant reports an acceptable health status.
    i. The applicant has not been sanctioned by a third-party payer (e.g. Medicare, Medicaid, etc.).
    j. The applicant has not been convicted of a felony, or any misdemeanor relating to:
        i. Professional practice.
        ii. Health care related matters.
        iii. Third-party reimbursement.
        iv. Acts of assault, battery, or any manner of violence against another person
        v. Use, abuse or possession of any controlled substance.
        vi. Operating a motor vehicle while impaired by alcohol or a controlled substance (DUI, DWAI, DWI, OWI, etc.)
    k. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

l. The applicant agreed to abide by the bylaws, and policies and procedures of the medical staff and hospital.

m. The applicant has completed the required number of CMEs as defined in the Medical Staff Documents.

n. The applicant has had adequate clinical activity at their primary facility or training program in the last two years.

2. **Category II Application**

a. Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, patient care issues, etc.).

b. There are discrepancies between information the applicant submitted, and information received from other sources that cannot be reconciled.

c. Privileges the applicant requested are outside of the scope of privileges for their specialty.

d. There are gaps in time for which the applicant has not accounted.

e. There are unsatisfactory peer references and/or prior affiliation references.

f. Disciplinary actions have been taken by a state licensing board or a state or federal regulatory agency, or there has been a criminal conviction for any offense specified in Section V.C.1.j. of this Credentialing Policy & Procedure Manual.

g. The applicant has experienced voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care organization.

h. The applicant has experienced removal from a provider panel of a managed care entity for reasons of unprofessional conduct or quality-of-care issues.

i. The applicant has been the subject of malpractice claims/settlements/judgments.

j. The applicant has had multiple healthcare organization affiliations in multiple areas during the past two years without reasonable justification, i.e. working as a locum tenens;

k. The applicant has not met the continuing medical education requirements set forth in the Medical Staff Documents.

l. If the Department Chair's findings are negative or differs from that of the Credentials Committee Chair or Medical Staff President, the application is automatically classified as Category II and processed accordingly.

D. **Applicant Interview and/or Orientation**

1. A personal interview may be required of all new applicants for membership to the Medical or Advanced Practice Staff if the Medical Staff Leadership has questions on information provided or discovered in the credentialing and privileging process. Affiliate staff members will not be required to participate in the interview and

orientation process since they will not hold hospital privileges. The interview will be clinical in nature and used to solicit information necessary to complete the application, credentials file, or to clarify various points. The interview will be conducted by the Medical Staff Leadership (appropriate Dept Chair, Chair or Vice Chair of Credentials Committee, Chief Clinical Officer/Physician-in-Chief and the Medical Staff President or President-Elect) and Medical Staff Services personnel.

2. A permanent record will be made of the interview including the general nature of questions asked, adequacy of the answers and the conclusion of the medical staff leadership relative to the qualifications and documented experience of the applicant for privileges requested.
3. If the applicant refuses to meet for an interview or attaches conditions to the meeting (i.e. refusing to meet without an attorney present or refusing to answer questions relevant to past behavior or clinical competence) the MSS shall inform the applicant that their application is incomplete and will not be processed until the interview is conducted and appropriate responses are received to specific questions. The same is true if the applicant fails to appear for a scheduled interview or meeting.
4. A copy of the applicant's government issued driver's license or passport will be viewed by a Medical Staff Services employee, or proxy, and recorded on the Verification of Identity Form. For telemedicine practitioners, the form will be completed by an employee of the contracted telemedicine company and forwarded to Medical Staff Services for inclusion in the provider's file.
5. The applicant must complete new provider orientation within 60 days of their medical/advanced practice staff appointment. Telemedicine and locum tenens providers are exempt from this requirement.

E. **Effect of Department Chair Report**

1. The appropriate Department Chair may not defer consideration of an application. A written report must be forwarded to the Credentials Committee upon receipt of a completed application. In the event a Department Chair is unable to formulate a report for any reason, the Department Chair must so inform the Credentials Committee.
2. The appropriate Department Chair must document their findings pertaining to adequacy of education, training and experience for all privileges requested. Reference to any criteria for privileges review must be documented. Specific reference to the credentials file should be made in support of all findings.
3. In the event the Department Chair determines that the applicant is not qualified for staff membership or privileges requested, all rationale for all unfavorable findings must be documented. Reference to any criteria for clinical privileges that are not met should be documented.
4. The Department Chair shall be available to the Credentials Committee to answer any questions that may arise with respect to his/her report.

F. **Credentials Committee Action**

1. The Credentials Committee shall review the complete provider profile, inclusive of but not limited to, peer references, affiliation references, verification of education and

training, licensure, board certification (if applicable), evidence of malpractice insurance and claims history, Department Chair report, and such other information available to it that may be relevant to consideration of the applicant's managed care credentialing, qualification for staff membership, and/or clinical privileges requested.

2. When the Credentials Committee recommendation is favorable to the applicant in all respects, a recommendation for staff membership and/or clinical privileges qualified by any appropriate conditions together with the complete provider profile , all supporting documentation, and the reports and recommendations of the Credentials Committee are forwarded to and available at the Medical Executive Committee. Exceptions to this process are defined in Section V.E.4 of this Credentialing Policies and Procedures Manual. Category I files may be presented to the Medical Executive Committee as consent agenda items.
3. When the Credentials Committee recommendation is adverse to the applicant, the reason for each recommendation shall be stated and supported by references to the completed application, along with all other documentation considered in a written report to the Medical Executive Committee. Exceptions to this process are defined in Section V.E.4 of this Credentialing Policies and Procedures Manual.
4. The Credentials Committee is the final approving body for all files presented to the Committee as **Managed Care Credentialing Review Only.**

G. **Medical Executive Committee Action**

1. The Medical Executive Committee shall review the Credentials Committee report and recommendations. The Medical Executive Committee shall consider the report and such other relevant information available to it.
2. The Medical Executive Committee's recommendation for appointment of staff membership and/or clinical privileges, qualified by any appropriate conditions, shall be forwarded to the governing body on the delineation of privileges for each practitioner privileged through the medical staff process. The written report to the Board shall include the Credentials Committee recommendation, the Department Chair's findings, and recommendations, accompanied by the Medical Executive Committee's recommendation.
3. In the event of an adverse decision, the applicant shall be entitled to the procedural rights as described in Article 8 of the Medical Staff Bylaws and to a fair hearing as described in Article 9 of the Medical Staff Bylaws.

H. **Quality and Patient Safety Committee of the Board of Director's Action**

1. **On Favorable MEC Recommendation**: The Quality and Patient Safety Committee (QPSC) of the Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made. If the QPSC of the Board's action is adverse to the applicant, a special notice will be sent to the applicant advising entitlement to the procedural rights as provided in Article 8 and 9 of the Medical Staff Bylaws.

2. **Without Benefit of MEC Recommendation**: If the QPSC of the Board does not receive a Medical Executive Committee recommendation within the time period specified in this Document, it may take action on its own initiative in the manner set forth in the hospital corporate bylaws. If such action is favorable, it shall become effective as the final decision of the QPSC of the Board. If such action is adverse, the administrator shall promptly so inform the applicant by special notice, and he/she is entitled to the procedural rights as provided in Article 8 and 9.
3. **After Procedural Right**: In the case of adverse Medical Executive Committee recommendation as outlined in this Document, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 8 and 9 of the Medical Staff Bylaws. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject the application for staff membership and/or clinical privileges.

I. **Conditional Approval**
The Credentials Committee, Medical Executive Committee, and/or Quality and Patient Safety Committee of the Board of Director's may conditionally approve a provider's credentialing file pending confirmation of receipt of an outstanding verification or document. Examples of this may include: verification of completion of a Residency or Fellowship program; **i**f confirmation has been received that the provider has met all requirements satisfactorily thus far and is on track to complete the program on a designated future date, verification of the issuance of a required State licensure or DEA registration; if the application for such licensure or registration has been submitted and is in a pending status, or verification of malpractice insurance coverage; if the coverage is for a future start date only. Other exceptions may be allowed on a case by case basis.

In the event a provider's file is granted conditional approval, the provider's privileges, and/or Medical Staff membership will not become active until the outstanding requirement(s) have been fulfilled. The Credentials Committee Chair will have the final approving authority for confirming that said outstanding documentation was received satisfactorily, and the date of this final approval will be documented as the Credentials Committee approval date, if prior to the Board approval date. If final approval of the provider's credentialing file is granted after the conditional Board approval date, this date will also become the initial effective date of the provider's privileges and/or Medical Staff membership.

Credentialing files granted conditional approval will not be submitted on any delegated payor trays or rosters until all required documentation and verifications have been received and the file has been granted final approval by the Credentials Committee Chair.

J. **Denial for Hospital's Inability to Accommodate Applicant**
A recommendation by the Medical Executive Committee, or a decision by the Board, to deny clinical privileges either:

1. On the basis of the hospital's present inability as supported by documented evidence to provide adequate facilities or supportive services for the applicant and his/her patients, or
2. On the basis of inconsistency with the hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented

shall not be considered adverse in nature and shall not entitle the applicant to the procedural rights as provided in Article 8 and 9 of the Medical Staff Bylaws.

K. **Conflict Resolution**
As outlined in the Medical Staff Bylaws Article 12.3 Joint Committee, whenever the Board's proposed decision will be contrary to the Medical Executive Committee's recommendation, the Board shall submit the matter to a Joint Committee. The Joint Committee shall consist of five persons from the Active Medical Staff and Board of Directors: two members of the Active Medical Staff appointed by the Medical Staff President and three members of the Board of Directors appointed by the Chair of the Board of Directors for review and recommendation.

L. **Notice of Final Decision**

1. Notice of the Board of Director's final decision shall be given through the President and CEO, or designee, to the chairman of the Medical Executive Committee, the Credentials Committee, and to the applicant.
2. Medical Staff Services will update the privileges module in the credentialing software to reflect the changes in clinical privileges for each provider.
3. Upon notice of final decision, Medical Staff Services will update patient and family marketing materials and provider directories to ensure that the information is consistent with the information obtained during the credentialing process.
4. A decision and notice of appointment will be sent to the applicant within 10 business days of the Credentials Committee's decision, for Managed Care Credentilaing Review Only files, and within 10 business days of the Quality and Patient Safety Committee of the Board of Director's final decision, for all other files, with the following items:
    a. the staff category to which the applicant is appointed.
    b. the Department to which the applicant is assigned.
    c. the clinical privileges, if any, that may be exercised.
    d. the timeframe of the applicant's appointment
    e. any special conditions or Focused Professional Practitioner Evaluation (FPPE) attached to the appointment.
    f. the demographic profile of the applicant which includes home address, office address and phone numbers.
    g. Prox Card/Identification Badge, if applicable.
    h. Welcome letter from Medical Staff Services.
    i. the applicant's dictation code with instructions, if applicable.

j. parking registration form and/or parking sticker, if applicable.

k. a pro-rated medical staff dues statement, if applicable.

M. **Reapplication after Adverse Appointment Decision**
An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of five years. Any such reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

N. **Time Periods for Processing**
Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required to act on an application and, except for good cause, shall be processed within the following time periods*:

Individual/Group	Time Period
Medical Staff Services//Physician Leadership (to collect, summarize and verify eligibility and/or need of specialty)	30 days
Children's Hospital & Medical Center Application sent, collected and primary source verified	30 days
Department Chair (to review and report findings)	30 days
Credentials Committee (review and determine recommendation)	30 days
Medical Executive Committee (provide additional review)	30 days
Quality and Patient Safety Committee of the Board of Directors (render final decision)	30 days
Total	180 days

*Applications for staff appointments for a provider who will be practicing in the State of Iowa must be fully processed, and the provider notified of the credentialing determination, within 90 days of Medical Staff Services receiving a completed initial credentialing application from the provider.

VI. REAPPOINTMENT PROCESS

A. **Application for Reappointment**

1. To be eligible for reappointment, an applicant must meet the basic qualifications set forth in the Medical Staff Bylaws (Section 3, for physicians, Section 5, for APPs) for initial appointment. Reappointment will occur at minimum, every 24 months, for all currently credentialed providers, regardless of whether they hold clinical privileges.Each application for reappointment to the Medical Staff shall be in writing, submitted on the Application form, and signed and dated by the applicant no more than 180 days prior to the Credentials Commitee or Quality and Patient Safety Committion (QPSC) of the Board of Directors (whichever is serving as the final

approving body).

2. As part of the recredentialing process, privileges may be granted, renewed or revised for a period not to exceed two years.
3. Approximately six months prior to the expiration of the current reappointment period, Medical Staff Services distributes the application for reappointment and requests information from the applicant relative to Children's Hospital & Medical Center. This includes, but is not limited to, request for reappointment, review and confirmation of current clinical privileges, and completion of Children's specific documents including a consent and release and restraint education (if applicable).
4. Each applicant for reappointment shall have the burden of producing adequate information for proper evaluation of the provider's current qualifications for reappointment. Failure, without good cause, to return the fully completed documents shall result in voluntary relinquishment of membership and/or clinical privileges at the expiration of the provider's current term.

B. **Content of Reappointment Application**
The complete reappointment application packet shall include:

1. Evidence of continuing medical education relevant to the staff member's specialty and privileges requested on reappointment; number of hours to be dictated by the Department of Health and Human Services/Division of Public Health/ Licensure Unit's requirements for renewal of professional licensure. This requirement will be waived if the applicant has completed their residency or fellowship program in the previous 24-month period. The medical or advanced practice staff member may sign the CME Attestation Form in lieu of submission of a list of continuing education courses attended.
2. Attestation of current physical, mental health, and substance abuse status as evidenced by any information received, as well as a signed and dated statement authorizing the collection of any information necesary to verify the information provided in the credentialing applciation. The Medical Executive Committee may request further information as deemed necessary.
3. A valid current medical license, as well as a current Drug Enforcement Agency (DEA) certification, if applicable, including any previously successful or currently pending challenges or voluntary and involuntary relinquishments to any licensure or registration.
4. A valid current Board Certificate, if applicable.
5. Compliance with Bylaws, and Medical Staff Documents, including:
    a. Timely, accurate and complete medical records.
    b. Patterns of care as reflected in Performance Improvement data.
6. Sanctions voluntary or involuntary of any kind imposed by any other health care institution, professional health care organization, or licensing authority.
7. Details about malpractice insurance coverage, claims, suits, and settlements, past or current, not previously reported.
8. Such other specific information about the staff member's professional ethics,

qualifications, and ability to work with others that may bear on his/her capability to provide good patient care in the hospital.

9. Clinical performance, judgment, clinical or technical skills as indicated by performance improvement activities. If Children's is not the practitioner's primary facility, the practitioner must submit documentation of the number of successful procedures in the prior two years for each privilege requested on the privilege list.
10. Proof that the applicant carries at least the minimum amount of professional liability insurance coverage as required in the Medical Staff Bylaws and any information on any liability claims in the past two years or current professional liability action including a consent to the release of information by the applicant's present and past malpractice insurance carriers and/or legal counsel, as well as a copy of the applicant's current professional liabiilty insurance certificate.
11. Information resulting from the ongoing professional practice evaluation; to be provided by the Department of Quality and Patient Safety.
12. Criminal Background Check (US and County search) which includes but is not limited to a query of the OIG and EPLS databases; to be performed by Medical Staff Services.
13. Reasonable evidence of current ability to perform privileges that may be requested.
14. The names and addresses of at least two providers, one of which must be of the same professional discipline, who have firsthand knowledge of the applicant's professional performance in the previous two years.
15. Documentation of successful completion of the restraint education test for applicable providers with privileges.
16. Documentation of enrollment in the NPDB-Proactive Data Service will be included in the file; with an update of the NPDB report run within the 180 day reapopintment processing timeframe; to be performed by Medical Staff Services.

C. **Affiliate Staff Reappointment**
Affiliate (membership only) staff members shall be reappointed biennially in accordance with the alphabetical reappointment schedule. The reappointment process for Affiliate staff shall consist of:

1. Printing demographic profile, sending it to the Affiliate Staff member to ensure accuracy and to determine if the member wishes to remain on the Affiliate Staff. Should the member wish an advancement to a category with privileges, appropriate documentation for a full reappointment and current clinical competency shall be completed.
2. Affiliate Staff Reappointment Application.
3. Querying the National Practitioner Data Bank.
4. Verification of current state license.
5. Completed peer recommendation questionnaire. If the member has retired from clinical practice, this requirement will be waived.

The documentation shall be reviewed by the Department Chair, Credentials Committee, Medical Executive Committee, and Quality and Patient Safety Committee of the Board of Directors.

D. **Verification of Information**

1. Primary source verification of information contained in the application shall be accomplished by Medical Staff Services, see Addendum A, noting that all the provider's active affiliations in the previous two years will be contacted. Medical Staff Services shall obtain information from Performance Improvement. Physician references, if applicable, will be queried in the National Provider Identifier (NPI) database to verify the practitioner listed is a practicing physician.
2. When all information is complete, the Credentialing Specialist for Reappointment shall review the application and make a preliminary determination of which category the application meets based on the criteria outlined in Section V.C. of this Credentialing Policy & Procedure Manual. For Reappointments, only history from the previous two years will be used as criteria for classification as a Category I or Category II file. Trends will also be monitored for consideration. All complete and categorized applications are then forwarded to the Department Chair for review. Any applications considered to not meet the Category I criteria are identified by the Department Chair and Chair of the Credentials Committee as a Category II application and may be returned to the Credentialing Specialist for Reappointment for the purpose of obtaining further information.

E. **Providers with No Activity at Reappointment**
To evaluate ongoing quality and competency as well as ensure a provider complies with Medical Staff Bylaws and policies, Medical Staff Services will obtain a Performance Improvement Profile for each practitioner in the reappointment process. In reviewing the reappointment activity data at Children's, if a practitioner has had no activity during the prior two years, a Performance Improvement Profile from the provider's primary facility will be requested. If this report also shows no activity during the prior two years, the provider will be advised of the requirement to switch to active staff, no privileges, or to affiliate staff which is defined as a membership category with no clinical privileges. If the documentation is not received within 30 days of the request, the change to affiliate staff will be automatically processed according to the medical staff process.

F. **Credentials Committee Action**
The Credentials Committee shall review a listing of Category I and Category II applications, the applicable profile form for all Category II applications, and other pertinent information available on each member being considered for reappointment. The Credentials Committee Chair will transmit to the Medical Executive Committee on the prescribed form the Committee's report and recommendation that appointment be renewed, renewed with modified staff category, and/or clinical privileges, or terminated. The Committee may also recommend that the Medical Executive Committee defer action. Any minority views shall also be reduced to writing and transmitted with the majority report. The Credentials Committee is the final approving body for all files presented to the Committee as **Managed Care Credentialing Review Only**.

G. **Medical Executive Committee Action**
The Medical Executive Committee shall review each information form and all other relevant

information available to it and shall, on the prescribed form, forward to the Quality and Patient Safety Committee of the Board, its report and recommendation that the appointment be either renewed, renewed with modified staff category and/or clinical privileges, or terminated. The committee may also defer action. Any minority views shall be reduced to writing and transmitted with the majority report.

H. **Final Processing and Board Action**

1. **On Favorable MEC Recommendation:** The Quality and Patient Safety Committee of the Board shall, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made. If the Quality and Patient Safety Committee of the Board's action is adverse to the applicant, a special notice will be sent to the applicant advising entitlement to the procedural rights as provided in Article 8 and 9 of the Medical Staff Bylaws.
2. **Without Benefit of MEC Recommendation:** If the Quality and Patient Safety Committee of the Board does not receive a Medical Executive Committee recommendation within the time period specified in this Document, it may take action on its own initiative in the manner set forth in the hospital corporate bylaws. If such action is favorable, it shall become effective as the final decision of the Quality and Patient Safety Committee of the Board. If such action is adverse, the administrator shall promptly so inform the applicant by special notice, and he/she is entitled to the procedural rights as provided in Article 8 and 9.
3. **After Procedural Right:** In the case of adverse Medical Executive Committee recommendation as outlined in this Document, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 8 and 9. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the staff or to reject the application for staff membership and/or clinical privileges.
4. **Notice of Final Decision**
    a. Medical Staff Services will update the privileges module in the credentialing software to reflect the changes in clinical privileges for each provider (if applicable).
    b. Upon notice of final decision, Medical Staff Services will update patient and family marketing materials and provider directories to ensure that the information is consistent with the information obtained during the credentialing process.
    c. Notice of the Board of Director's final decision shall be given through the President and CEO, or designee, to the chairman of the Medical Executive

Committee, the Credentials Committees, and to the applicant.

d. A decision and notice of reappointment will be sent to the applicant within 10 business days of the Credentials Committee's decision, for all files that are Managed Care Credentialing Review Only files, and within no more than 10 business days of the Quality and Patient Safety Committee of the Board of Director's final decision, for all other files, with the following items, as applicable:
    i. The staff category to which the applicant is reappointed.
    ii. The Department to which assigned.
    iii. The clinical privileges, if any, that may be exercised.
    iv. Any special conditions or Focused Professional Practitioner Evaluation (FPPE) attached to the reappointment.
    v. Time frame of reappointment

I. **Basis for Recommendations**
Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment, if applicable, shall be based upon such member's current clinical competence, peer recommendations, participation in continuing education, professional ability and clinical judgment in the treatment of patients, his/her professional ethics, his/her discharge of staff obligations, his/her compliance with the Medical Staff Bylaws and Documents, his/her cooperation with other practitioners and with patients, and other matters bearing on his/her ability and willingness to contribute to good patient care practices in the hospital.

J. **Time Periods for Processing**
Transmittal of the reappointment application to a staff member and his/her return of it shall be carried out in accordance with this Document. Thereafter and except for good cause, each person, and committee required by the Medical Staff Bylaws to act thereon shall complete such action in a timely fashion such that all reports and recommendations concerning the reappointment of a Staff Member shall have been transmitted to the Medical Executive Committee for its consideration and action and to the Board for its action pursuant to this Document, all prior to the expiration date of the staff membership of the member being considered for reappointment.

VII. REQUESTS FOR MODIFICATION OF APPOINTMENT, CATEGORY OR PRIVILEGES

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, or clinical privileges by submitting a formal request for modification of staff category or clinical privileges to Medical Staff Services, the chair of the Department of assignment, Chief Clinical Officer/Physician-in-Chief or the President of the Medical Staff. This request shall state the specific modification of staff category or clinical privileges. This request will be reviewed by Medical Staff Services to determine eligibility and collection of any supporting documentation as outlined on the privilege request form to determine competence. Such application shall be processed as follows:

1. A modification of clinical privileges shall be accompanied by a completed Request for Additional Privileges form and include documentation of training and/or experience in the privilege requested. If the privilege is not currently available, the provider must submit the Request for Additional Privileges form with the New Technology/Procedure Briefing section completed as outlined in Medical Staff Bylaws Article 7.2-3.
2. All requests for modification of appointment/privileges shall have the following documentation requested by Medical Staff Services before being forwarded for review and recommendation to the appropriate Department Chair/Credentials Committee/Medical Executive Committee/ Quality and Patient Safety Committee of the Board of Directors:
    a. Verification of current State licensure
    b. Verification of current DEA, CDS, or CSA (if applicable)
    c. Current reports from the National Practitioner Data Bank and/or documentation of enrollment in the NPDB Proactive Data Service which will include but not be limited to any reports from the OIG/EPLS
    d. Verification of clinical competence completed by a peer reference, if applicable
    e. Verification of training in the privilege requested, if applicable
    f. Successful completion of the appropriate test with a passing grade, if applicable
    g. Performance Improvement data, if applicable
3. A modification in staff status shall be based upon evidence that the applicant meets the qualifications set forth in the Medical Staff Documents for the desired staff category.
4. A decrease in staff status may result from a request by the staff member to voluntarily decrease their medical staff category or from determination during the reappointment process of a member's noncompliance with category requirements or lack of clinical activity at the hospital.
5. Whenever a physician contemplates a reduction in practice activity, the provider should notify the Medical Staff Services or the President of the Medical Staff in writing. provider planning to retire should also specify, in writing, their effective date of retirement from practice.
6. Notice of Final Decision
    a. Medical Staff Services will update the privileges module in the credentialing software to reflect the changes in clinical privileges for each provider (if applicable).
    b. Upon notice of final decision, Medical Staff Services will update patient and family marketing materials and provider directories to ensure that the information is consistent with the information obtained during the credentialing process.
    c. Notice of the Board of Director's final decision shall be given through the President and CEO, or designee.to the chairman of the Medical Executive Committee, the Credentials Committees, and to the applicant.
    d. A decision and notice of modification of staff category or clinical privileges will be sent to the applicant within no more than 10 business days of the Quality and Patient Safety Committee of the Board of Director's final decision, with the following items, as applicable:
        i. The staff category to which the applicant is appointed.

ii. The Department to which assigned.

iii. The clinical privileges, if any, that may be exercised.

iv. Any special conditions or Focused Professional Practitioner Evaluation (FPPE) attached to the appointment.

VIII. RESIGNATIONS

Resignations from the Medical or Advanced Practice Staff will be submitted by the provider to Medical Staff Services. The Credentialing Specialist will contact the provider to offer affiliate staff membership. The resignation will be submitted to the Credentials Committee, Medical Executive Committee and Quality and Patient Safety Committee of the Board for acceptance of the resignation or consideration of Honorary Staff Status. Upon acceptance, Medical Staff Services will update the privileges module in the credentialing software to reflect the changes in clinical privileges and membership for each provider. Upon acceptance of resignation, Medical Staff Services will update patient and family marketing materials and provider directories to ensure that the information is current.

IX. HONORARY RECOGNITION

A. **Definition**

1. Member of the Active Medical or Advanced Practice Staff who is no longer actively practicing medicine and who has been voted to Honorary Status by the Medical Executive Committee and approved by the Board in recognition of their contributions to Children's Hospital & Medical Center or the children's health in general.
2. Physician or Advanced Practice Provider in the region who has not been on Active Medical or Advanced Practice Staff but who has made extraordinary contributions to children's health.
3. Notable factors in achieving Honorary Status would include long career of serving children in the region with excellent reputation, major leadership roles on the medical staff, major national leadership roles, innovative research that significantly impacts pediatric practice, etc.

B. **Nominating Process**

1. As providers ask to retire from practice or the Medical Staff of Children's Hospital & Medical Center that provider can be nominated by a provider on the Credentials Committee or Medical Executive Committee for Honorary Status
2. The nominating provider will provide a brief synopsis of the nominee's career and contributions either to CHMC or children's health in general.
3. The Medical Staff Office will supply the records of the nominee's activity and contributions on committees, etc., if requested.

X. INTERIM/TEMPORARY PRIVILEGES

A. Temporary privileges may be granted only in one (1) circumstance: to fulfill an important patient care, treatment, or service need. Any applicant desiring temporary privileges, when they

are an initial applicant with a complete application that raises no concerns and is awaiting review and approval of the MEC and the Board, will be processed using the expedited credentialing process as defined in MS61 – Expedited Board Approval.

B. Interim/temporary privileges may be granted by the CEO, Chief Clinical Officer/Physician-in-Chief or designee upon recommendation of the President of the Medical Staff or their designee provided there is verification of current licensure and current competence.

C. Interim/Temporary privileges will be granted for a limited period, not to exceed 120 days.

XI. DISASTER PRIVILEGING

A. When the disaster plan has been implemented and the immediate needs of patients in the facility can not be met, the EVP, Chief Clinical Officer/Physician-in-Chief or designee will work with the Manager or Director of Medical Staff Services or designee to credential volunteer medical or advanced practice staff as outlined in the Disaster Manual and Emergency Operations Plan.

B. Disaster privileges will be granted on a case by case basis after verification of identity and licensure. Before granting disaster privileges, the volunteer licensed independent practitioners (LIP) must present a valid ID issued by a state or federal government agency and one of the following:

    1. Current picture hospital ID with professional designation
    2. Current license to practice or primary source verification of license by Medical Staff Services
    3. Identification indicating that the volunteer LIP has the authority to render patient care, treatment and services during a disaster or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized organization either federal or of the State of Nebraska.
    4. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer provider's ability to act as a licensed independent practitioner during a disaster.

C. Those individuals granted disaster privileges will be identified as such with green emergency medical/advanced practice staff badges.

D. Medical Staff Services will attempt to verify licensure upon request for disaster privileges. Should this not be possible, verification will occur as soon as practical after the immediate situation is under control, and except in extraordinary circumstances, will be completed within 72 hours from the time the volunteer provider presents to the organization. If verification is not completed within 72 hours, the reason it could not be performed in this time frame will be documented in the verification documents. The time the privileges were granted will be documented, and the hospital president or designee will make a decision within 72 hours regarding whether to continue the privileges.

E. The patient care, treatment, and services provided by volunteer LIPs will be monitored and overseen by the physician manager of the department in which services are provided. Oversight of the performance of these providers will include one of the following: direct

observation, mentoring or medical record review.

F. Disaster privileges shall automatically terminate once the state of emergency no longer exists or when the volunteer LIP's services are no longer required, as determined by the hospital president or designee. Disaster privileges may be revoked at any time. The termination of disaster privileges shall be final, and the medical staff's hearing and appellate review procedures shall not apply.

XII. REINSTATEMENT

Reinstatement to the Medical Staff can be accomplished in one of three ways.

A. An individual resigned from the medical or advanced practice staff or returning from a leave of absence. The time frame from the effective date of resignation or leave of absence does not exceed what would normally be the biennial reappointment period. In this instance:

    1. A Release of Record/Information form is sent to the individual requesting permission to obtain all information regarding his/her last reappointment.
    2. The previous file is reviewed to ensure there were no issues regarding the resignation.
    3. A Children's specific packet is sent to the individual, which contains the Children's consent and release, criminal background check release, privilege requests and an application for reinstatement. This application form differs from the reappointment application form in that it asks all the questions regarding malpractice, convictions, etc. that might have occurred in the last two years.
    4. Once all the above information is received, the application is processed as if it were a reappointment application; however, noting on the Credentials Committee, Medical Executive Committee and Quality and Patient Safety Committee of the Board agenda's that it is a reinstatement. Upon approval, Medical Staff Services will update the privileges module in the credentialing software to reflect the changes in clinical privileges for each provider.

B. An individual who has resigned or taken a leave of absence and the time frame exceeds that which would be the normal reappointment time is treated as follows:

    1. If the request for reinstatement is submitted within 30 days of the expiration of privileges due to exceeding the normal reappointment time frame, and all of the required paperwork has been submitted, the individual will be automatically reinstated.
    2. If the request for reinstatement exceeds 30 days, the individual will be required to submit a new application for membership and/or privileges as if they were a new applicant.

C. Providers who have been suspended for failure to renew their license, board certification, or malpractice insurance, may be immediately reinstated by providing proof of compliance. Providers who have been suspended for failure to complete medical records may be immediately reinstated upon completion of the delinquent medical records and notification of this to Medical Staff Services. This applies only if the provider is in compliance with all other requirements of medical staff membership or advanced practice staff status, was in good

standing at the time that the non-compliant issue occurred and the suspension was less than five working days.

XIII. EXPIRABLES

Items in the provider's credentialing and recredentialing file will expire periodically. The following items will be collected and or verified by Medical Staff Services prior to their expiration:

- State of Nebraska or Iowa (if applicable) License
- Malpractice Insurance
- DEA, CDS, or CSA certificate, if applicable
- Board Certification, Maintenance of Certification and/or requirement to obtain board certification, if applicable
- Life Support certifications, if required for privileging

XIV. NATIONAL PRACTITIONER DATA BANK – PROACTIVE DISCLOSURE SERVICES (NPDB-PDS)

A. **Proactive Disclosure Services (NPDB-PDS)**
As of February 2009, Medical Staff Services began enrolling all credentialed medical and advanced practice staff members, and Allied Health Professionals in the NPDB-PDS (continuous query). In the NPDB-PDS, provider are enrolled and renewed annually, and the hospital is notified immediately when a report is posted for a provider currently enrolled in the NPDB-PDS for the hospital. Confirmations of enrollment and renewal will be maintained in the provider's file and in the credentialing software. As outlined by the NPDB Reporting Requirements, all State Medical and Dental Boards, the Drug Enforcement Administration (DEA), the Office of the Inspector General (OIG), Medicaid/Medicare and other Federal programs report exclusions on a monthly basis, therefore, a separate monthly query of these sanction lists is not necessary. The Medical Staff Office does however complete additional monthly monitoring of the Nebraska Disciplinary Actions Against Professional and Occupation Licenses report to ensure that all reports made are addressed in a timely fashion.

When notification of a report is received, Medical Staff Services will immediately review the report and any existing reports in the provider's credentials file for trends. The report will be recorded in the credentialing software. The report and/or file will be reviewed by the Chairman of the Credentials Committee and/or Medical Staff President. The Chairman of the Credentials Committee and/or the Medical Staff President will document on the appropriate review form the determination of what, if any, further action is necessary.

B. **Reporting to the National Practitioners Data Bank**
The Hospital, or its authorized representative, namely the EVP,Chief Clinical Officer/Physician-in-Chief, or designee, or the Director, Medical Staff Services, or designee, shall report all Adverse Actions which are based upon the individual medical or advance practice staff member, or Allied Health Professional's competence or professional conduct that affects or

could adversely affect the health or welfare of a patient or patients to the National Practitioners Data Bank, and applicable state licensing board, as required by the Healthcare Quality Improvement Act of 1986, only when such Adverse Action becomes a final action, and only after the hearing process set forth in Article 9 of the Medical Staff Bylaws has been followed or waived, if applicable, unless otherwise required by law.

XV. Automated Credentialing System

As of October 2019, Medical Staff Services began using an automated credentialing system. Electronic signatures and unique electronic identifiers may be used to document verification. Controls are in place to ensure that the electronic signature or unique identifier can only be entered by the signatory. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable. Web crawlers may also be used to verify credentialing information from approved sources. Paper files and documents are no longer utilized or stored on-site.

XVI. Quality Review/Second Set of Eyes

The Director of Medical Staff Services, or designee, will perform a quality audit of all completed credentialing files for both initial and reappointment. The checklist will be compared against the contents of the file to ensure that all required elements are accounted for and red flags are noted. Each document will be checked for appropriate primary source verification documentation, as well as a date stamp. Any modifications made to documents in the application will be reviewed using both qualitative and quantitative analysis methods to ensure that there is appropriate justification in the file for the modification, and that unauthorized modification or deletion of information did not occur.

In addition to the initial audit of all files, The Director of Medical Staff Services, or designee, will complete a subsequent audit of a minimum of 5% or 50 files, whichever is greater, of the total volume of all files completed quarterly to assess for the following:

- Review of job roles and current user access to ensure system access is still appropriate for the role requirements, in compliance with policies MS-26 Confidentialigy of Credentialing Information and MS-04 Access to Medical Staff Privileges/Status Infromation. May be done in conjunction with IT.
- Review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system’s audit trail function or change tracking reporting capability.
- Review of data modifications/changes/updates to all credentialing data and documents not tracked through the electronic credentialing system's audit trail; pdf document attachments, verifications obtained from an outside source, etc.
- Assess for accuracy, appropriateness, and compliance with policies.

A Credentialing System Controls Oversight Report will be completed for each audit period. Findings will be documented and appropriate action taken when applicable. A quarterly monitoring process will be implemented to assess the effectiveness of any action taken on all findings until improvement for each finding is demonstrated over a minimum of three consecutive quarters.

Additionally, each quarterly audit will include a verification of all attested application data (CME hourse, Sedation/PCA/NCA volumes) for a minimum of 10 files per audit period.

XVII. Nondiscriminatory Credentialing and Recredentialing

Children's Hospital & Medical Center does not base credentialing decisions on an applicant's race, religion, disability, ethnic/national identity, gender, gender identity, age, sexual orientation or patient type (e.g. Medicaid) in which the practitioner specializes, or any other such prejudice. Credentialing decisions will be based on multiple criteria related to professional competency, quality of care, and the appropriateness by which health services are provided. Medical Staff Services monitors credentialing decisions to prevent discrimination. Monitoring includes, but is not limited to:

1. Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
2. Quality audits of all credentialing files (in-process, denied, and approved files) to identify potential discriminatory practices in selecting providers.
3. Annual audits of provider complaints for evidence of alleged discrimination during the credentialing process.

Attachments

PSV Source Grid final 3.1.22.pdf

Approval Signatures

Step Description	Approver	Date
EVP Chief Officer & Physician in Chief	Christopher Maloney: EVP, Chief Clinical Officer, Physician-in-Chief	04/2022
Owner/SME - Manager	Sara Watson: CH - Dir Med Staff Services	04/2022

Children's
HOSPITAL & MEDICAL CENTER

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	**Verification Method/Source**	**Initial**	**Recred**	**Primary or Secondary?**	**Timeframe**
Background Check	PT Research: https://secure.ptrionline.com/escreening/loginentrance.asp Hire Right: https://ows01.hireright.com/login/	X	X	Primary	Obtained within 180 days of Credentials Committee & QPSC Meeting dates
Board Certification: Physicians	ABMS: https://certifacts.abms.org/Login.aspx or directly through Cactus via ABMS Direct Connect Select ABPNS: www.abpns.org ABP: https://www.abp.org/content/verification-certification AOA/AOiA: https://aoaprofiles.org/sign_in.cfm	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
Board Certification: Dentists/ Orthodontists	ABPD: https://www.abpd.org/Content/Verifications.aspx ABO: https://abo.roc-p.com/VerifyStatus/Default.aspx ABGD: https://www.abgd.org/credentialverifiction.php ABOMS: https://www.aboms.org/verifications	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
Board Certification: APP's	**Physician Assistants (PA)** NCCPA: https://www.nccpa.net/ **Nurse Anesthetists (CRNA)** NBCRNA: https://portal.nbcrna.com/nbcrnassa/f?p=NBCRNASSA:17800 **Nurse Practitioner (APRN-NP)** NCC: https://www.nccwebsite.org/Verifications/Request ANA/ANCC: https://ebiz.nursingworld.org/Login?returnurl=https://www.nursingworld.org/Certapps/Verification&SSOL=Y	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	**Verification Method/Source**	**Initial**	**Recred**	**Primary or Secondary?**	**Timeframe**
	AANP: https://www.aanpcert.org/verification/select PNCB: https://www.pncb.org/verification AACN: https://www.aacn.org/certification/verify-certification				
Board Certification: AHP's	**Audiologists** https://www.asha.org/certification/ **Speech Language Pathologist** https://www.asha.org/certification/ **Lactation Consultants** https://iblce.org/public-registry/	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
Controlled Substance Registration (CSR/CDS/CSA)	Verified through the State licensure website	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
DEA number	Verified directly through Cactus via the DEA online database or via https://apps.deadiversion.usdoj.gov/webforms2/spring/validationLogin?execution=e1s1	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
ECFMG	Verification of certification through the ECFMG: https://cvsonline2.ecfmg.org/	X		Primary	Current and verified within 180 days of Credentials

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	**Verification Method/Source**	**Initial**	**Recred**	**Primary or Secondary?**	**Timeframe**
					Committee & QPSC Meeting dates
Education, Training, Completion of Residency	Verification of completion direct from the institution (email, fax, letter, or phone verifications are acceptable) or verified through the: AMA: https://fsso.ama-assn.org/login/account/login AOA/AOIA: https://aoaprofiles.org/sign_in.cfm ECFMG: https://cvsonline2.ecfmg.org/ National Student Clearinghouse: https://secure.studentclearinghouse.org/vs/Index	X		Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
License	Verified through the State licensure website for all states in which the provider is delivering care. NE: https://www.nebraska.gov/LISSearch/search.cgi IA: https://ibplicense.iowa.gov/PublicPortal/Iowa/IBPL/publicsearch/publicsearch.jsp or https://eservices.iowa.gov/PublicPortal/Iowa/IBON/public/license_verification.jsp or https://eservices.iowa.gov/PublicPortal/Iowa/IBM/licenseQuery/LicenseQuery.jsp?Profession=Physician Other state licensing boards will be verified when applicable.	X	X	Primary	Current and verified within 180 days of Credentials Committee & QPSC Meeting dates
Life Support Certifications	BLS, PALS, PEARS, ACLS, ATLS, NRP, etc. Copy of applicable life support certification card obtained from the provider.	X	X	Secondary	Current at time of credentialing decision
Malpractice Claims History	Verified directly from the malpractice carrier (past 5 years, if applicable, for initial applicants; to include residency/fellowship years, past 2 years for recred) **and** through continuous query of the NPDB: https://iqrs.npdb.hrsa.gov/	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	**Verification Method/Source**	**Initial**	**Recred**	**Primary or Secondary?**	**Timeframe**
Malpractice/ Liability Insurance	Copy of the insurance face sheet (COI) obtained directly from the malpractice carrier for the last five years of coverage; if applicable. Must include the amounts, policy name, policy number, provider's name, effective date, and the date of expiration. May include federal tort letter or attestation of tort coverage, if applicable. May include NELF letter, if applicable.	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
Medicaid/ Medicare Sanctions	50 States Medicaid/Medicare excluded provider lists verified through the FACIS Level 3 Search included in the PT Research background check. The Fraud and Abuse Control Information Systems (FACIS) Level 3 search includes sanctions, exclusions, and disciplinary actions from over 800 sources. Federal Sources: HHS-OIG, SAM, DEA, USDA, Tricare. State Sources: All states that maintain a state Medicaid exclusion list, State boards of certification and licensure in health care professions, HHS Disciplinary Actions/Administrative Actions, State-sanctioned providers, debarments, prescription abuse and misconduct. Additional investigative sources at State and Federal levels are included when involved with a major health care investigation. Applicants who have their background check completed through Hire Right will have this verification completed through a separate FACIS Level 3 verification, or through review of the Nebraska and Iowa Medicaid Excluded Providers List via the following websites: NE: http://dhhs.ne.gov/Pages/Program-Integrity-Sanctioned-Providers.aspx IA: https://dhs.iowa.gov/ime/providers/program-integrity	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
Nebraska Medicaid ID Verification	Verified through the Nebraska Medicaid Provider Enrollment portal: https://www.nebraskamedicaidproviderenrollment.com/	X	X	Primary	Current and verified within 180

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	Verification Method/Source	Initial	Recred	Primary or Secondary?	Timeframe
	Account/Login.aspx?ReturnUrl=%2f or by confirmation of enrollment email if enrolling concurrent to credentialing.				days of Credentials Committee & QPSC Meeting dates
National Provider Identification (NPI)	NPI: https://npiregistry.cms.hhs.gov/	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
OIG	Included in the FACIS Level 3 Search of the Background Check or through OIG website: https://exclusions.oig.hhs.gov/Default.aspx	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
SAM	Included in the FACIS Level 3 Search of the Background Check or through SAM website: https://sam.gov/SAM/pages/public/searchRecords/search.jsf	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
State Sanctions/ Limitations on Licensure	Verified through continuous query of the NPDB, appropriate state licensing agencies, or through the FACIS Level 3 search included in the Background Check. The Fraud and Abuse Control Information Systems (FACIS) Level 3 search includes sanctions, exclusions, and disciplinary actions from over 800 sources. Federal	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	**Verification Method/Source**	**Initial**	**Recred**	**Primary or Secondary?**	**Timeframe**
	Sources: HHS-OIG, SAM, DEA, USDA, Tricare. State Sources: All states that maintain a state Medicaid exclusion list, State boards of certification and licensure in health care professions, HHS Disciplinary Actions/Administrative Actions, State-sanctioned providers, debarments, prescription abuse and misconduct. Additional investigative sources at State and Federal levels are included when involved with a major health care investigation.				Meeting dates
Verification of hospital privileges	Verification obtained directly from the provider's primary hospital affiliation(s) in the form of a verification letter, or completion of a questionnaire.	X	X	Primary	Verified within 180 days of Credentials Committee & QPSC Meeting dates
Verification of ID	Verified by Passport, State Driver's License, Hospital ID	X		Primary	Verified at the time of, or prior to, the provider first providing patient care services
Work History:	**Initial:** Verification of the last ten years of relevant work experience as a health professional, if applicable. If the provider does not have ten years of work experience, all work experience back to the completion of professional education will be verified. Verification will be obtained from the primary source (email, fax, letter, or phone verifications are acceptable) whenever possible. If verification from primary source is not possible due to lack of response after a minimum of three (3) documented attempts, or due to the institution being closed or unable to access employment files due to	X	X	Primary or Secondary	Verified within 180 days of Credentials Committee & QPSC Meeting dates

Verification Source and Timeframe Requirements

* All verifications are initialed and dated by the person performing the verification/review and/or initials and dates are present on the checklist

Element	Verification Method/Source	Initial	Recred	Primary or Secondary?	Timeframe
	extenuating circumstances, verification will be obtained from the secondary source; CV and/or application. **Recred:** Verification of all primary hospital affiliations within the previous 24 months will be obtained from the primary source (email, fax, letter, or phone verifications are acceptable).				